CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Amended After Comments)

907 KAR 1:044. Coverage provisions and requirements regarding community mental health center behavioral health services.

RELATES TO: KRS 194A.060, 205.520(3), 205.8451(9), 422.317, 434.840-434.860, 42 C.F.R. 415.208, 431.52, 431 Subpart F

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 210.450, 42 U.S.C. 1396a-d,

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the **Medicaid Program** coverage provisions and requirements regarding community mental health center (CMHC) behavioral health services **provided to Medicaid recipients**.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

(2) "Department" means the Department for Medicaid Services or its designee..

(3) "Enrollee" means a recipient who is enrolled with a managed care organization

(4) "Face-to-face" means occurring:

(a) In person; or

(b) If authorized by 907 KAR 3:170, via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(5) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(6) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(7) "Mental health associate" means an individual who meets the mental health associate requirements established in the Community Mental Health Center Behavioral Health Services Manual.

(8)[~~(7)~~] "Professional equivalent" means an individual who meets the professional equivalent requirements established in the Community Mental Health Center Behavioral Health Services Manual.

(9)[~~(8)~~] "Provider" is defined by KRS 205.8451(7).

(10)[~~(9)~~] "Qualified mental health professional" means an individual who meets the requirements established in KRS 202A.0011(12).

(11)[~~(10)~~] "Recipient" is defined by KRS 205.8451(9).

Section 2. Requirements for a Psychiatric Nurse. A registered nurse employed by a participating community mental health center shall be considered a psychiatric or mental health nurse if the individual:

(1) Possesses a Master of Science in nursing with a specialty in psychiatric or mental health nursing;

(2)(a) Is a graduate of a four (4) year nursing educational program with a Bachelor of Science in nursing; and

(b) Possesses at least one (1) year of experience in a mental health setting;

(3)(a) Is a graduate of a three (3) year nursing educational program; and

(b) Possesses at least two (2) years of experience in a mental health setting;

(4)(a) Is a graduate of a two (2) year nursing educational program with an associate degree in nursing; and

(b) Possesses at least three (3) years of experience in a mental health setting; or

(5) Possesses any level of education with American Nursing Association certification as a psychiatric or mental health nurse.

Section 3. Community Mental Health Center Behavioral Health Services Manual. The conditions for participation, services covered, and limitations for the community mental health center behavioral health services component of the Medicaid Program shall be as specified in:

(1) This administrative regulation; and

(2) The Community Mental Health Center Behavioral Health Services Manual.

Section 4. Covered Services. (1) Behavioral health services covered pursuant to this administrative regulation and pursuant to the Community Mental Health Center Behavioral Health Services Manual shall be[~~include:~~

~~(a)~~] rehabilitative mental health and substance use disorder services including:

(a)[~~1.~~] Individual outpatient therapy;

(b)[~~2.~~] Group outpatient therapy;

(c)[~~3.~~] Family outpatient therapy;

(d)[~~4.~~] Collateral outpatient therapy;

(e)[~~5.~~] Therapeutic rehabilitation services;

(f)[~~6.~~] Psychological testing;

(g)[~~7.~~] Screening;

(h)[~~8.~~] An assessment;

(i)[~~9.~~] Crisis intervention;

(j)[~~10.~~] Service planning;

(k)[~~11.~~] A screening, brief intervention, and referral to treatment;

(l)[~~12.~~] Mobile crisis services;

(m)[~~13.~~] Assertive community treatment;

(n)[~~14.~~] Intensive outpatient program services;

(o)[~~15.~~] Residential crisis stabilization services;

(p)[~~16.~~] Partial hospitalization;

(q)[~~17.~~] Residential services for substance use disorders;

(r)[~~18.~~] Day treatment;

(s)[~~19.~~] Comprehensive community support services;

(t)[~~20.~~] Peer support services; or

(u)[~~21.~~] Parent or family peer support services[~~; or~~

~~(b) Physical health services including:~~

~~1. Physical examinations; or~~

~~2. Medication prescribing and monitoring~~].

(2)(a) To be covered under this administrative regulation, a service listed in subsection (1) of this section shall be:

1. Provided by a community mental health center that is:

a. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and

b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671;[~~and~~]

2. Provided in accordance with:

a. This administrative regulation; and

b. The Community Mental Health Center Behavioral Health Services Manual; and

3. Medically necessary.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

Section 5. Electronic Documents and Signatures. (1) The creation, transmission, storage, or other use of electronic signatures and documents shall comply with requirements established in KRS 369.101 to 369.120 and all applicable state and federal laws and regulations.

(2) A CMHC choosing to utilize electronic signatures shall:

(a) Develop and implement a written security policy which shall:

1. Be complied with by each of the center's employees, officers, agents, and contractors; and

2. Stipulate which individuals have access to which electronic signatures and password authorization;

(b) Ensure that electronic signatures are created, transmitted, and stored securely;

(c) Develop a consent form that shall:

1. Be completed and executed by each individual utilizing an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(d) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 6. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, on the same day of service.

(2) For example, if a recipient is receiving a behavioral health service from an independently enrolled behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient by a community mental health center on the same day of service.

Section 7. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

a. Name;

b. Social Security number;

c. Date of intake;

d. Home (legal) address;

e. Health insurance information;

f. Referral source and address of referral source;

g. Primary care physician and address;

h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information, if available, regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

j. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

(i) This administrative regulation;

(ii) The provider's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening **if the community mental health center performed the screening**;

b. Assessment; and

c. Disposition;[~~and~~

~~d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;~~]

3. A complete history including mental status and previous treatment;

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services;

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the**:**

a. Cabinet for Health and Family Services upon request; **or**

b. Managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;

3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

4. Readily accessible; and

5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient; and

(c) Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record **within forty-eight (48) hours of [~~on~~]** the date that the individual provided the service.

(4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least six (6)[~~five (5)~~] years from the date of the service or until any audit dispute or issue is resolved beyond six (6)[~~five (5)~~] years.

(b) After a recipient's death or discharge from services, a provider shall maintain the recipient's **health** record for the longest of the following periods:

1. Six (6) years unless the recipient is a minor; or

2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Part 164.

(6) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(7)(a) A provider's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit; and

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the[~~treatment~~] plan of care if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a mental health associate working under supervision or a professional equivalent working under supervision shall be co-signed and dated by a licensed supervising professional within thirty (30) days.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(8) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) A provisional diagnosis;

(b) A referral for further consultation and disposition, if applicable; or

(c)1. If applicable, termination of services and referral to an outside source for further services; or

2. If applicable, termination of services without a referral to further services.

(9)[~~(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.~~

~~(b)~~] Any change to a recipient's[~~treatment~~] plan of care shall be documented, signed, and dated by the:

(a) Rendering practitioner; and

(b) Recipient or recipient's representative[~~provider~~].

(10)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Dated;

3. Titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not covered under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(11)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's[~~treatment~~] plan <u>of care</u>;

b. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who was terminated from receiving services shall be fully completed within ten (10) days following termination.

(12) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(13)(a) Except as established in paragraph (b) of this subsection, if a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring CMHC[~~provider~~] shall, if the recipient gives the CMHC[~~provider~~] written consent to do so,[~~forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient~~] within ten (10) business days of the transfer or referral, transfer the recipient's **health** records in a manner that complies with the **health** records' use and disclosure requirements as established in or required by:

1.a. The Health Insurance Portability and Accountability Act;

b. 42 U.S.C. 1320d-2 to 1320d-8; and

c. 45 C.F.R. Parts 160 and 164; or

2.a. 42 U.S.C. 290ee-3; and

b. 42 C.F.R Part 2.

(b) If a recipient is transferred or referred to a residential crisis stabilization unit, a psychiatric hospital, a psychiatric distinct part unit in an acute care hospital, or an acute care hospital for care or treatment, the transferring CMHC shall, within forty-eight (48) hours of the transfer or referral, transfer the recipient's **health** records in a manner that complies with the **health** records' use and disclosure requirements as established in or required by:

1.a. The Health Insurance Portability and Accountability Act;

b. 42 U.S.C. 1320d-2 to 1320d-8; and

c. 45 C.F.R. Parts 160 and 164; or

2.a. 42 U.S.C. 290ee-3; and

b. 42 C.F.R Part 2.

(14)(a) If a CMHC's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of a provider, the health records regarding recipients to whom the CMHC has provided services shall:

1. Remain the property of the CMHC; and

2. Be subject to the retention requirements established in subsection (4) of this section.

(b) A CMHC shall have a written plan addressing how to maintain health records in the event of a provider's death.

Section 8. Medicaid Program Participation Compliance. (1) A CMHC shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a CMHC receives any duplicate payment or overpayment from the department **or managed care organization**, regardless of reason, the CMHC shall return the payment to the department **or managed care organization that issued the duplicate payment or overpayment**.

(b) Failure to return a payment to the department in accordance with paragraph (a) of

this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. Auditing Authority. The department **or the managed care organization in which an enrollee is enrolled** shall have the authority to audit any**:**

(1) Claim**;**

(2) Health[~~, Medical~~] record**;[~~,~~]** or

(3) Documentation associated with the claim or **health[~~medical~~]** record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeal Rights. (1) An appeal of an adverse action by the department regarding a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

Section 13. Incorporation by Reference. (1) The "Community Mental Health Center Behavioral Health Services Manual", December[~~May~~] 2014, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, 6th Floor

West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

907 KAR 1:044

REVIEWED:

Date	Lisa Lee, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 1:044
Contact person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program community mental health center (CMHC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program CMHC services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program CMHC services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program CMHC services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment clarifies that this administrative regulation sets the requirements for behavioral health services provided in a community mental health center; removes a reference to physical health services; changes the term "treatment plan" to "plan of care"; extends the timeframe for maintaining a health record of a recipient who received services from a CMHC from five (5) years to six (6) years; clarifies that notes recorded by a behavioral health practitioner working under supervision must be co-signed by the supervising professional within thirty (30) days (previously no timeframe was stated); establishes that the transfer of a health record of a recipient transferring to a residential crisis stabilization unit, psychiatric hospital, psychiatric distinct part unit of an acute care hospital, or to an acute care hospital shall be done within forty-eight (48) hours in contrast to the ten (10) day timeframe for other such transfers; and amends the incorporated material by synchronizing provisions with the latest behavioral health state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS.) The amendment after comments clarifies that a CMHC does not have to document a screening given to a recipient if the CMHC did not perform the screening; clarifies that health records must be signed by the practitioner who provided the service within forty-eight (48) hours; changes the term “record” to “health record” in a few places for consistency; clarifies that a duplicate payment or overpayment received by a provider must be returned to the managed care organization which sent the duplicate payment or overpayment; clarifies that managed care organizations have the authority to audit

health records and associated documentation; and amends the material incorporated by reference – the Community Mental Health Center Behavioral Health Services Manual. Amendments to the incorporated material include adding licensed clinical alcohol and drug counselors (LCADCs) and licensed clinical alcohol and drug counselor associates (LCADCAs) as authorized practitioners contingent and effective upon approval by the Centers for Medicare and Medicaid Services (CMS); establishing that a CMHC must meet the staffing requirements established in the Office of Inspector General's CMHC licensure requirements administrative regulation (902 KAR 20:091); revising the staffing section of the manual from addressing minimum and additional staff requirements to a section listing all authorized staff along with corresponding qualifications; adding certified psychologists with autonomous functioning to the professionals authorized to supervise staff; adding certified psychologists to those who can provide certain services as well as supervise mental health associates; restricting licensed psychological associates to working under the supervision of a board-approved licensed psychologist; clarifying that supervision means "billing supervision" and defining "billing supervision" and "billing supervisor"; establishing that a billing supervision arrangement cannot violate or substitute for clinical supervision rules established by respective licensure boards; correcting the plan of care requirements establishing that a thirty (30) day review of a plan of care is only required for residential services for substance use disorders and intensive outpatient program services - for all other services the requirement is a review every six (6) months; inserting a reference to the psychology chapter of Kentucky Revised Statutes – KRS Chapter 319 – regarding psychological testing requirements; inserting an option for CMHCs to utilize electronic prescribing; inserting provisions regarding substance use treatment for pregnant women that were inadvertently omitted; inserting a few exceptions to the requirement that face-to-face contact between a practitioner and recipient is required in order for the service to be reimbursable; adding peer support specialists to those authorized to provide mobile crisis services; correcting the list of those who can supervise comprehensive community support associates and certified alcohol and drug counselors as only billing supervisors are authorized to supervise those practitioners; clarifying staff note requirements; replacing the term "client" with "recipient"; and clarifying non-covered services consistent with other related behavioral health administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to clarify provisions and to synchronize provisions with those currently approved by CMS (in order to ensure receipt of federal funding for CMHC behavioral health services.) The amendment after comments to the administrative regulation is necessary to clarity requirements. Additionally, amendments to the incorporated material are necessary for clarity as well as to synchronize requirements (shared by representatives of the Kentucky Psychological Association and Kentucky Board of Examiners of Psychology) with requirements established in Kentucky law. Adding licensed clinical and alcohol drug counselors and licensed clinical and alcohol drug counselor associates (contingent and effective upon approval by the Centers for Medicare and Medicaid Services) to the authorized practitioners is necessary in response to legislation (HB 92 of the 2015 Regular Session of the General Assembly) which created these two (2) behavioral health professionals.

(c) How the amendment conforms to the content of the authorizing statutes: The

amendment conforms to the content of the authorizing statutes by clarifying provisions and synchronizing provisions with those currently approved by CMS (in order to ensure receipt of federal funding for CMHC behavioral health services.) The amendment after comments conforms to the content of the authorizing statutes by clarifying requirements. The amendment after comments conforms to the content of the authorizing statutes by clarifying requirements and also by synchronizing psychological practice requirements with those established in Kentucky law.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by clarifying provisions and synchronizing provisions with those currently approved by CMS (in order to ensure receipt of federal funding for CMHC behavioral health services.) The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying requirements. The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying requirements and also by synchronizing psychological practice requirements with those established in Kentucky law.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Community mental health centers will be affected by this amendment as will Medicaid recipients who receive services from CMHCs. There are fourteen (14) such centers.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. CMHCs will have to keep health records regarding recipients for at least six (6) years rather than five (5) years; transfer health records (when applicable) to urgent settings within forty-eight (48) hours; and ensure that supervising professionals sign notes recorded by practitioners working under supervision within thirty (30) days.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No additional cost is anticipated.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). CMHCs and Medicaid recipients receiving services from CMHCs will benefit by the department's continued receipt of federal funding from CMS for CMHC behavioral health services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost as a result of the amendment.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implemen-

tation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 1:044
Contact person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization’s provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky’s Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter

than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 1:044
Contact person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the amendment.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not anticipate additional revenues for state or local government as a result of the amendment.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS does not anticipate additional costs as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:044

Summary of Material Incorporated by Reference
Amended After Comments

The “Community Mental Health Center Behavioral Health Services Manual”, April 2015 edition replaces the December 2014 edition which replaced the May 2014 edition.

The April 2015 amendments to the manual include adding licensed clinical alcohol and drug counselors (LCADCs) and licensed clinical alcohol and drug counselor associates (LCADCAs) as authorized practitioners contingent and effective upon approval by the Centers for Medicare and Medicaid Services (CMS); establishing that a community mental health center (CMHC) must meet the staffing requirements established in the Office of Inspector General’s CMHC licensure requirements administrative regulation (902 KAR 20:091); revising the staffing section of the manual from addressing minimum and additional staff requirements to a section listing all authorized staff along with corresponding qualifications; adding certified psychologists with autonomous functioning to the professionals authorized to supervise staff; adding certified psychologists to those who can provide certain services as well as supervise mental health associates; restricting licensed psychological associates to working under the supervision of a board-approved licensed psychologist; clarifying that supervision means “billing supervision” and defining “billing supervision” and “billing supervisor”; establishing that a billing supervision arrangement cannot violate or substitute for clinical supervision rules established by respective licensure boards; correcting the plan of care requirements establishing that a thirty (30) day review of a plan of care is only required for residential services for substance use disorders and intensive outpatient program services - for all other services the requirement is a review every six (6) months; inserting a reference to the psychology chapter of Kentucky Revised Statutes – KRS Chapter 319 – regarding psychological testing requirements; inserting an option for CMHCs to utilize electronic prescribing; inserting provisions regarding substance use treatment for pregnant women that were inadvertently omitted; inserting a few exceptions to the requirement that face-to-face contact between a practitioner and recipient is required in order for the service to be reimbursable; correcting the list of those who can supervise comprehensive community support associates and certified alcohol and drug counselors as only billing supervisors are authorized to supervise those practitioners; replaced the term “client” with “recipient”; clarifying non-covered services consistent with other related behavioral health administrative regulations; and clarifying staff note requirements.

The December 2014 amendments included establishing that this is the Community Mental Health Center (CMHC) Behavioral Health Services Manual rather than the CMHC Services Manual as effective January 1, 2015 CMHCs will be authorized to provide primary care services and the Department for Medicaid Services is

promulgating a separate administrative regulation which will establish CMHC primary care service provisions; eliminating extraneous language regarding the Medicaid Program; clarifying the behavioral health professionals who can supervise professional equivalents; establishing that an associate level practitioner can render services under the supervision of an array of behavioral health professionals licensed to practice independently rather than a behavioral health professional within the associate level practitioners discipline (for example, previously a certified social worker (CSW) was only authorized to render services under the supervision of a licensed clinical social worker but via the amendment a CSW can render services under the supervision of a licensed psychologist, licensed professional clinical counselor, licensed marriage and family therapists, and more); replacing the term “treatment plan” with the term “plan of care” to synchronize terminology used in other Medicaid behavioral health administrative regulations; adopting plan of care requirements that are also established being established for behavioral health service organizations; clarifying that in order for services to a recipient to be reimbursable a diagnosis shall be recorded within the recipient’s third visit except for mobile crisis services, crisis intervention, screenings, assessments, and screening, brief intervention, and referral to treatment for a substance use disorder (SBIRT) - previously no exceptions were listed); clarifying that health records must be retained for six (6) years rather than five (5) as six (6) is the current federal standard; inserting a definition of “face-to-face” which includes a Telehealth option if so authorized in the Department for Medicaid Services’ Telehealth administrative regulation (907 KAR 3:170); clarifying that multi-family group outpatient therapy groups include related individuals (prior language prohibited related individuals from being in the same group outpatient therapy group); revising the description of mobile crisis services, therapeutic rehabilitation services, and assertive community treatment to synchronize with the provisions in the corresponding state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS); deleting medication assisted treatment from the services as the current state plan amendment approved by CMS does not include this service; clarifying what constitutes continuous nursing services (which is a requirement for residential services for substance use disorders); clarifying that the sixteen (16) bed limit for residential services for substance use disorders [a federal limit as CMS views any structure with over sixteen (16) beds as being an institution for mental disease (IMD)] does not apply if all of the recipients in the structure are under twenty-one (21) years of age or over sixty-five (65) years of age; clarifying peer support requirements consistently with the current state plan amendment approved by CMS; eliminating various reimbursement provisions as reimbursement is covered in another administrative regulation; eliminating language regarding electronic signature usage as this is already addressed in 907 KAR 1:044; adding certified alcohol and drug counselors (CADCs) to the practitioners authorized to provide individual outpatient therapy, group outpatient therapy, family outpatient therapy, collateral outpatient therapy, assessments, and screenings; deleting CADCs from the list of practitioners authorized to provide therapeutic rehabilitation services; adding peer support specialists to those authorized to provide mobile crisis services.

The revised manual contains sixty-five (65) pages.